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103D CONGRESS
1ST SESSION

S. 1456

To amend the Public Health Service Act to provide for health insurance coverage for pregnant women and children, and for other purposes.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 14 (legislative day, SEPTEMBER 7), 1993

Mr. DODD introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To amend the Public Health Service Act to provide for health insurance coverage for pregnant women and children, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Children and Pregnant Women Health Insurance Act of 1993".

(b) TABLE OF CONTENTS.—The table of contents is as follows:

Sec. 1. Short title; table of contents.

TITLE I—UNIVERSAL HEALTH INSURANCE COVERAGE FOR CHILDREN AND PREGNANT WOMEN

Sec. 101. Universal health insurance coverage for children and pregnant women.
Sec. 102. Conforming amendments.

TITLE II—PEDIATRIC REPRESENTATION ON HEALTH CARE REFORM BOARDS

Sec. 201. Membership of health care reform boards.

TITLE III—EFFECTIVE DATE

Sec. 301. Effective date.

TITLE I—UNIVERSAL HEALTH INSURANCE COVERAGE FOR CHILDREN AND PREGNANT WOMEN

SEC. 101. UNIVERSAL HEALTH INSURANCE COVERAGE FOR CHILDREN AND PREGNANT WOMEN

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended—

(1) by redesignating title XXVII (42 U.S.C. 300cc et seq.) as title XXVIII; and

(2) by inserting after title XXVI the following new title:

"TITLE XXVII—HEALTH INSURANCE FOR CHILDREN AND PREGNANT WOMEN

"SEC. 2700. DEFINITIONS.

"As used in this title:

"(1) ALLIANCE.—The term 'Alliance' means a Health Insurance Purchasing Alliance established in the United States.

"(2) CHILD.—The term 'child' means an individual who is less than 22 years of age.

"(3) COVERED SERVICES.—The term 'covered services' means the benefits and cost sharing limitations required for qualified health plans under this title.

"(4) FAMILY.—The term 'family' means an individual, the individual's spouse, any child of either such individual, and the legal guardian of any such child if such guardian resides with the child.

"(5) FAMILY ADJUSTED TOTAL INCOME.—The term 'family adjusted total income' means, with respect to an individual, the sum for the individual and all the other family members of the individual, of the adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986), determined without the application of paragraphs (6) and (7) of such section and without the application of section 162(l) of such Code, plus the amount of social security benefits which is not included in gross income under section 86 of such Code.

"(6) LEGALLY RESIDING.—The terms 'legally residing in the United States' or 'legally residing' mean a citizen of the United States, an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of any provision of 207(c) of the Immigration and Nationality Act or as a result of the application of the provisions of section 208 or 212(d)(5) of such Act).

"(7) OFFICIAL POVERTY LINE.—The term 'official poverty line' means, for an individual in a family, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673 of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(8) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' means a health insurance plan, a health maintenance organization, or any other plan for providing health care that meets the requirements imposed by this title.

"(9) RESIDE.—The term 'reside' refers to the individual's principal place of residence.

"(10) UNITED STATES.—The term 'United States' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.

"PART A—UNIVERSAL COVERAGE FOR CHILDREN AND PREGNANT WOMEN

"SEC. 2701. CHILDREN'S COVERAGE MANDATE.

"(a) ENTITLEMENT.—Every child who is legally residing in the United States shall be entitled to enrollment in a qualified health plan for the purpose of obtaining access to all covered services. Coverage for any child under a qualified health plan shall be continuous from the effective date of this title or, if later, from the birth of the child, until the child reaches the age of 22. The Alliance established to serve the region in which the child resides shall have direct responsibility for enrolling such children and pregnant women in qualified health plans.

"(b) ALLIANCES.—Not later than January 1, 1995, all Alliances established in the United States shall identify every child born or legally residing in its geographic region and enroll such children in a qualified health plan. A physician or other provider that has rendered health care to a child who is not enrolled in a qualified health plan may

inform the appropriate Alliance of such fact and the Alliance shall enroll the child in a qualified health plan and ensure that the physician or provider is compensated for any covered services rendered as if the child had been enrolled in the plan at the time care was sought.

"(c) PREGNANT WOMEN.—Upon application to the Alliance serving the region where she is legally residing, or upon seeking medical care from a physician or provider, every pregnant woman shall be enrolled in a qualified health plan for the duration of the pregnancy plus at least one calendar quarter post partum, and any physician or provider rendering a covered service to a pregnant woman shall be compensated for such service as if the individual were enrolled in a qualified health plan at the time care was sought.

"PART B—BENEFITS

"SEC. 2711. QUALIFIED HEALTH PLANS.

"(a) IN GENERAL.—A qualified health plan shall meet the requirements of this section.

"(b) BENEFITS.—A qualified health plan shall provide at least the covered services identified in section 2712. Nothing in this section shall be construed as preventing a qualified health plan from including benefits in addition to those required in section 2713.

"(c) LIMITATIONS ON EXCLUSIONS.—A qualified health plan—

"(1) may not deny, limit, or condition the coverage (or benefits) under the plan with respect to required health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual; and

"(2) may not exclude coverage with respect to required health services related to treatment of a preexisting condition.

"(d) COST SHARING.—A qualified health plan may not impose premiums in excess of those permitted by the Alliance, or deductibles, copayments, or coinsurance with respect to covered services, in excess of what is permitted under this title.

"SEC. 2712. COVERED HEALTH SERVICES.

"(a) REQUIRED HEALTH SERVICES.—

"(1) IN GENERAL.—Except as otherwise provided in this part, a qualified health plan shall provide coverage for—

"(A) preventive care services (as defined in section 2713);

"(B) major medical services (as defined in section 2714); and

"(C) extended medical services (as defined in section 2715).

"(2) REQUIRED HEALTH SERVICES DEFINED.—As used in this title, the term 'required health services' means the health services described in paragraph (1), subject to the deductible and coinsurance permitted with respect to such services.

"(b) REQUIRED OUTREACH SERVICES.—In addition to the required health services under subsection (a), each Alliance shall provide (or make payment) for outreach services to link low-income enrolled individuals with needed required health services. Such outreach services shall include—

"(1) transportation;

"(2) child care at service sites;

"(3) translation services;

"(4) case/care coordination;

"(5) screening follow-ups; and

"(6) health promotions.

"(c) OPTIONAL ADDITIONAL SOCIAL SERVICES.—An Alliance may provide (or make payment) for social services (such as family psycho-social support, therapeutic foster care, pediatric day treatment, parent training, and in-home crisis management) that are necessary to ensure the health of enrolled individuals.

"(d) STANDARDS.—The Secretary shall establish standards to be applied with respect to required health services under this title.

"SEC. 2713. PREVENTIVE CARE SERVICES.

"(a) DEFINED.—As used in this title, the term 'preventive care services' means the following items and services furnished in accordance with any applicable periodicity schedule established under subsection (b):

"(1) Child preventive care, including—

"(A) routine office visits;

"(B) routine immunizations; and

"(C) routine laboratory tests.

"(2) Prenatal care, including care of all complications of pregnancy.

"(3) Care of newborn infants, including attendance at high-risk deliveries and normal newborn care.

"(4) Family planning services.

"(5) Child abuse assessment.

"(6) Preventive dental care for children.

"(b) PERIODICITY SCHEDULES.—

"(1) PEDIATRIC CARE.—With respect to preventive care services furnished to children, the Secretary shall establish a schedule of periodicity that reflects the general, appropriate frequency with

which such care should be provided routinely to healthy children. Such schedule shall be established in consultation with the American Academy of Pediatrics.

"(2) PRENATAL CARE.—With respect to preventive care services for pregnant women, the Secretary shall establish a schedule of periodicity that reflects the appropriate frequency with which such care should be provided to pregnant women, taking into account age and other risk factors. Such schedule shall be established in consultation with the American College of Obstetricians and Gynecologists.

"(c) NO APPLICATION OF DEDUCTIBLE OR COINSURANCE.—A qualified health plan may not impose deductibles or coinsurance with respect to preventative care services.

"SEC. 2714. MAJOR MEDICAL SERVICES.

"(a) DEFINED.—As used in this title, the term 'major medical services' means the following items and services (to the extent such items and services are not preventive care services, and subject to subsection (b)):

"(1) Inpatient and outpatient hospital services.

"(2) Physicians' services.

"(3) Professional services of certified nurse midwives, nurse practitioners, and other health pro-

fessionals (to the extent authorized under applicable State law).

"(4) Diagnostic tests (including laboratory tests).

"(5) Ambulance services.

"(6) Short-term home health services.

"(7) Medical and surgical supplies and durable medical equipment.

"(8) Corrective eyeglasses and lenses and hearing aids.

"(9) prescription drugs, insulin, and medically recommended nutritional supplements.

"(10) Acute dental care.

"(b) TREATMENT OF MENTAL HEALTH SERVICES, SUBSTANCE ABUSE SERVICES, AND DEVELOPMENTAL AND LEARNING DISABILITY SERVICES AS EXTENDED MEDICAL SERVICES.—Major medical services do not include items and services for the treatment of mental illness, for the treatment of substance abuse, or for the treatment of developmental and learning disabilities, but shall include psychiatric services. Such services for such treatment are included in the definition of extended medical services under section 2715.

"(c) APPLICATION OF DEDUCTIBLE AND COINSURANCE.—In accordance with sections 2721 and 2722, a

qualified health plan may impose deductibles and coinsurance with respect to major medical services, subject to the limitations specified in such sections.

"SEC. 2715. EXTENDED MEDICAL SERVICES.

"(a) DEFINED.—As used in this title, the term 'extended medical services' means the following items and services (to the extent they are not preventive care services, and subject to subsection (b)):

"(1) Items and services described in section 2714(a) for the treatment of mental illnesses connected with substance abuse and for the treatment of development and learning disabilities (other than the educational component of such treatment).

"(2) Orthodontia (other than cosmetic orthodontia).

"(3) Substance abuse services.

"(4) Speech, occupational, and physical therapy.

"(5) Hospice care.

"(6) Respite care.

"(7) Short-term skilled nursing facility services.

"(8) Nutritional assessment and counseling.

"(b) PLAN OF CARE REQUIREMENT.—A qualified health plan shall provide for coverage of extended medical services only in accordance with a plan of care that—

"(1) is developed in cooperation with the attending primary care physician; and

"(2) applies to all required health services.

"(c) APPLICATION OF DEDUCTIBLE AND COINSURANCE.—In accordance with sections 2721 and 2722, a qualified health plan may impose a deductible and coinsurance with respect to extended medical services, subject to the limitations specified in such sections.

"SEC. 2716. SCOPE OF COVERAGE.

"(a) NO AMOUNT, DURATION OR SCOPE LIMITATIONS.—A qualified health plan may not impose any limitation on the amount, duration, or scope for required health services.

"(b) CONSTRUCTION.—Subsection (a) shall not be construed as requiring coverage of—

"(1) preventive care services in a frequency greater than the frequency specified in the appropriate periodicity schedule established under this title;

"(2) extended medical services which are not specified in a plan of care under this title; or

"(3) major medical services or extended medical services which are not reasonable and medically necessary.

"(c) IN GENERAL.—Except as otherwise provided in this section, section 1862 of the Social Security Act shall apply to expenses incurred for items and services provided under this title in the same manner as such section applies to items and services provided under title XVIII of such Act.

"(d) PREVENTIVE SERVICES.—In the case of preventive services provided consistent with the applicable periodicity schedule—

"(1) such services shall be considered to be reasonable and medically necessary; and

"(2) shall not be subject to exclusion through the operation of paragraph (1), (7), or (12) of section 1862(a) of the Social Security Act (as incorporated under subsection (c)).

"(e) USE OF SAME NATIONAL COVERAGE DECISION REVIEW PROCESS.—The provisions of section 1869(b)(3) of the Social Security Act shall apply under this title in the same manner as such provisions apply under title XVIII of such Act. Any determination under such title that, under subsection (a), would apply under this title shall not be subject to review under this subsection.

"PART C—PAYMENT FOR SERVICES

"SEC. 2721. APPLICATION OF DEDUCTIBLE.

"(a) IN GENERAL.—Except as provided in this section and section 2713, a qualified health plan may provide for an annual deductible with respect to expenses for required health services of members of a family, not to exceed $200 with respect to any family.

"(b) DEDUCTIBLE DOES NOT APPLY TO PREVENTIVE CARE SERVICES OR OUTREACH AND OPTIONAL SERVICES.—The deductible established under subsection (a) may not be applied to preventive health services or to services provided under subsection (b) or (c) of section 2712.

"SEC. 2722. COINSURANCE FOR MAJOR MEDICAL SERVICES AND EXTENDED MEDICAL SERVICES.

"(a) COINSURANCE RATES.—Subject to subsection (b), and section 2731, a qualified health plan may require coinsurance with respect to payments for required health services, in an amount not to exceed—

"(1) 20 percent of the costs involved with respect to major medical services; and

"(2) 30 percent of the costs involved with respect to extended medical services.

"(b) NO COINSURANCE FOR PREVENTIVE CARE SERVICES OR OUTREACH AND OPTIONAL SERVICES.—There shall be no coinsurance under this title in the case

of preventive care services provided consistent with any applicable periodicity schedule or to services provided under subsection (b) or (c) of section 2712.

"SEC. 2723. LIMIT ON COST-SHARING FOR REQUIRED HEALTH SERVICES.

"Whenever in a calendar year the amount of deductibles and coinsurance required for family members with respect to required health services under a qualified health plan that are furnished during the year exceeds 10 percent of family adjusted total income, but in no event to exceed $1,000 for an individual or $3,000 per family, payment of benefits under the plan for the family members for required health services furnished during the remainder of the year shall be paid without the application of any coinsurance.

"PART D—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

"SEC. 2731. ASSISTANCE FOR INDIVIDUALS.

"(a) INDIVIDUALS WITH INCOME BELOW 133 PERCENT OF POVERTY LEVEL.—Except as otherwise provided in this section, in the case of a child whose family adjusted total income does not exceed 133 percent of the official poverty line, the qualified health plan shall waive any deductible or coinsurance under the plan for the individual and the individual's family.

"(b) PREGNANT WOMEN AND INFANTS BELOW 185 PERCENT OF POVERTY LEVEL.—In the case of a pregnant woman or child under 1 year of age whose family adjusted total income does not exceed the percentage (established by the State under section 1902(l)(2)(A)(i) of the Social Security Act as of the date of the enactment of this title) of the official poverty line, the qualified health plan shall waive any deductible or coinsurance under the plan for such individual.

"(c) INDIVIDUALS WITH INCOME BELOW 200 PERCENT OF POVERTY.—In the case of an individual not described in subsection (a) or (b), and whose family adjusted total income is less than 200 percent of the official poverty line, the qualified health plan shall provide for reductions in deductibles and coinsurance.

"(d) INDIVIDUALS WITH INCOME BELOW 400 PERCENT OF POVERTY.—In the case of an individual not described in subsection (a) or (b), and whose family adjusted total income is less than 400 percent of the official poverty line, the qualified health plan shall provide for reductions in premiums.

"(e) COMPENSATION FOR WAIVERS.—Qualified health plans shall be compensated for waivers of copayments and deductibles under this section.".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2701 through 2714 of the Public Health Service Act (42 U.S.C. 300cc through 300cc–15) are redesignated as sections 2801 through 2814, respectively.

(2) Sections 465(f) and 497 of such Act (42 U.S.C. 286(f) and 289(f)) are amended by striking out "2701" each place that such appears and inserting in lieu thereof "2801".

SEC. 102. CONFORMING AMENDMENTS.

(a) FEDERAL FINANCIAL PARTICIPATION FOR STATE CONTRIBUTION TOWARD CHILDREN AND PREGNANT WOMEN'S HEALTH SERVICES.—

(1) TRANSITION RULES.—The Secretary of Health and Human Services shall, by regulation, develop transition rules for ensuring that States that are required under title XIX of the Social Security Act to pay for medical services to certain children shall continue to maintain their level of effort in contributing to the cost of providing medical services to children enrolled in qualified health plans pursuant to title XXVII of the Public Health Service Act.

(2) PREMIUM.—Section 1905(a) of the Social Security Act is amended—

(A) in paragraph (24), by striking the period and inserting "; and"; and

(B) by adding after paragraph (24) the following new paragraph:

"(25) paying the State's share of any premium to enroll a child or pregnant woman in a qualified health plan pursuant to title XXVII of the Public Health Service Act."

(b) USE OF UNIFORM CLAIM FORMS.—The Secretary of Health and Human Services shall develop (after consultation with insurers) uniform claims forms for the submission of any claims for payment that may be required by qualified health plans under the Children and Pregnant Women's Health Insurance Act of 1993.

(c) PREEMPTION OF CERTAIN STATE AND FEDERAL REQUIREMENTS.—Effective on January 1, 1995, no State shall establish or enforce any law or regulation that requires the offering, as part of a qualified health plan with respect to any pregnant woman or child, of any services, category of care, or services of any class or type of provider that is less than the benefits required to be provided pursuant to title XXVII of the Public Health Service Act.

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TITLE II—PEDIATRIC REPRESENTATION ON HEALTH CARE REFORM BOARDS

SEC. 201. MEMBERSHIP OF HEALTH CARE REFORM BOARDS.

Any board or advisory panel that may be created under State or Federal health care reform legislation for purposes of reviewing fees, standards of care, outcomes research or other matters affecting the quality of care provided to children and pregnant women, shall include representation of pediatricians, family physicians, obstetricians, and experts and advocates on maternal and child health.

TITLE III—EFFECTIVE DATE

SEC. 301. GENERAL EFFECTIVE DATE.

This Act shall become effective on the date of enactment of this Act regardless of whether regulations have been promulgated by the Secretary of Health and Human Services as required under title XXVII of the Public Health Service Act.

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